complete mastication. Treitel calls attention to the influence of crusts of dried nasal secretion in the pharynx. The hawking and straining due to these often cause vomiting and irritation of the stomach. Not less harmful are the chemical decompositions caused by nasal secretions; while in some persons the odor of the secretions causes loss of appetite. A number of cases are cited in which the relations of nasal disease to symptoms on the part of the stomach were observed.

In one case of ethmoid abscess the dyspeptic symptoms were probably due rather to the intense headache than to other results of the local disease. In all the cases the removal of the nasal disease was followed by improvement of the stomach. A few cases are cited from the literature. The influence of the gastric disease on the nasal mucous membrane is alluded to.

Tuberculosis of the Appendix Vermiformis.—SCHUCHARDT (*Berliner klin. Wochenschrift*, 1897, No. 41) reports a case of this kind in a man, aged twenty-two years, then serving his year in the army. In September, 1896, he was taken with pain in the ileo-cæcal region. Later a hard tumor appeared, reaching the size of an apple. Fever developed; the tumor showed fluctuation. An operation for appendicitis failed to reveal the appendix, but opened a cavity the size of a walnut, lined with tuberculous granulations. The wound healed partially, leaving a small fistula. Five months later a second operation was performed. The appendix was found adherent to the small intestine, into which it had perforated. The mucous membrane at the site of the adhesion was tuberculous. A wedge-shaped piece of the intestine was removed with the appendix. The patient was discharged in five weeks with a small granulating wound.

Gastrodiaphany.—OPPLER (*Archiv für Verdauungs-Krankheiten*, Band iii. p. 334) gives a very useful review of the literature of this subject, with references to thirty-five original articles. Of the conclusions drawn by the author, the following are most important: The instruments of Kuttner and Jacobson and of Meltzing are to be preferred. The light should not be stronger than four candles. The transillumination must take place in a room entirely dark. The stomach must be clean, the intestines as empty as possible of contents (and gas), and the bladder empty. The illumination should be made both in the horizontal and standing positions. With the empty stomach there is often no connected picture, but only a series of roundish bright spots, and in the horizontal position, on account of the sinking of the lamp, there may be no illumination at all. If the lamp is allowed to glide along the greater curvature the centres of the bright spots produced approximate the position of the curvature. In the case of a thick abdominal wall the results are erroneous, as they are in all cases when strong light is necessary. The thinner the abdominal wall the more exact are the results, though the boundaries may seem lower. It seems, therefore, that the lower boundary (greater curvature) is lower in some cases than has been supposed, but not so much so as some claim, and not in all cases. The so-called megalogastria in persons with thick abdominal walls depends on an error. By the illumination with from 500 to 1500 c.cm. of water in the stomach a bright spot is produced, the right upper boundary of which is made by the right and left lobes of the liver, the left upper boundary by the spleen. These boundaries are more exact than can be made by any other method. The lower boundary is from 4 to 11 cm. lower in the upright than in the horizontal position, and on the whole somewhat lower than with the stomach empty. It is not certain that the line is lower in the majority of cases than the level of the iliac crests. The stomach when partly filled with water extends toward the right. The greater curvature is elevated at first, but then descends. In the horizontal position the light area moves plainly in inspiration. Standing, the displacement is slight, and in case the stomach is low down not present. In the rare cases of complete ptosis the motion is slight even in the horizontal position.

As regards pathological conditions the author says: Transillumination is able to define the position of a gastric tumor and to furnish some evidence as to its transparency, and sometimes to make probable the presence of a tumor that could not otherwise be demonstrated. The method can also assist in the recognition of a tumor of the edge of the liver, or an enlargement, tumor, or displacement of the spleen. An enlargement of the stomach can be made out by transillumination; a displacement can be claimed only where at the same time a marked motor disturbance can be demonstrated. A slight motor disturbance—gastric atony—can perhaps be demonstrated by the slight difference in the degree of mobility, by partial and complete filling with water, and by the failure of the greater curvature to rise when a small amount of water is introduced. If the upper border of the light area is separated from the liver by a dark zone which does not belong to the stomach, we can diagnosticate a gastroptosis. A low position of the greater curvature may be due to: 1. A physiological megalogastria. 2. A pathological dilatation. 3. Gastroptosis. 4. A combination of the latter with one of the two others.

The respiratory mobility of the light area is not sufficient in differential diagnosis, as dilatation and megalogastria both cause limited mobility in the upright position, and the mobility is present in gastroptosis of mild grade. Abnormal conditions of the stomach, such as vertical position and loop-shape, can sometimes be recognized.

Finally, the author emphasizes the necessity of employing all the methods of diagnosis, as transillumination does not replace them, may often lead to error, and can often be dispensed with.

Hæmochromogen as a Blood Test, with Especial Reference to the Detection of Blood in Urine.—For converting blood-coloring matter into hæmochromogen, DONOGANY makes use of pyridin and observes the color-change, or makes a spectroscopic examination. About 10 c.cm. of urine are treated with 1 c.cm. of ammonium sulphide and 1 c.cm. of pyridin. An orange color appears, especially distinct if looked at from above toward a white background. If the urine is very dark a control must be compared with the test. It is still better if the urine can be examined spectroscopically. If the ammonium sulphide and pyridin are old, they give a green or brown color to the urine, changed to yellow by the addition of ammonium hydrate. Feces and vomitus are to be dissolved in 20 per cent. caustic soda solution, the pyridin added, and the filtrate examined spectroscopically. Sputum is to be boiled with caustic soda until dissolved.

Control tests show that the spectroscopic method can show oxyhæmoglobin